Social and financial nursing/midwifery enterprise to empower women

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Midwifery

- Lancet series on Midwifery, June 2014, sets out a framework for quality maternal and newborn care

- What care is provided, how and by whom + the health system requirements
• **Definition of midwifery for the series**

Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life.

Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women’s individual circumstances and views, and working in partnership with women to **strengthen women’s own capabilities to care for themselves and their families**
Midwifery

• Midwifery empowers more than one person/group of people:
  – The care giver
  – The care receiver
  – The family/close surroundings of the care receiver
  – The newborn child

• This is fed by:
  – Education
  – Work surroundings
  – Work/life experience
  – Socio-economic and cultural situation
  – Exposure to other thought streams/ideologies/media
**Midwifery**

State of the World’s Midwifery 2014

**MIDWIFERY 2030**

A PATHWAY TO HEALTH

**PLANNING AND PREPARING** means:
- Delaying marriage
- Completing secondary education
- Providing comprehensive sexual education for boys and girls
- Protecting yourself against HIV
- Maintaining a good health and nutritional status
- Planning pregnancy using modern contraceptive methods

**ENSURING A HEALTHY START** means:
- Maintaining your health and preparing yourself for pregnancy, childbirth and the early months as a new family
- Receiving at least four antenatal care visits, which include discussing birth preparedness and making an emergency plan
- Demanding and receiving professional supportive and preventative midwifery care to help you and your baby stay healthy, and to deal with complications effectively, should they arise

**SUPPORTING A SAFE BEGINNING** means:
- Safely accessing midwifery services with the partner of your choice when labour starts
- Finding respectful, supportive and preventive care, provided by competent midwives who have ready access to the equipment and supplies they need and receiving emergency obstetric care if required
- Participating in decisions about how you and your baby are cared for
- Having the privacy and space to experience birth without unnecessary disturbance and interventions
- Being supported by a collaborative midwifery team in the event that you do need emergency obstetric care

**CHALLENGE**

Only 4 of the 73 countries have a midwifery workforce that is able to meet the universal need for the essential interventions for RMNCH.

**SOLUTION**

Midwives care provide 87% of the needed essential care for women and newborns if educated and registered to international standards.

**IMPACT**

Investing in midwives could give a 16-fold return on investment.

**PROGRESS**

Bangladesh is aiming to educate 500 midwives who can potentially save around 36,000 lives.

**CREATING A FOUNDATION FOR THE FUTURE** means:
- Starting to breastfeed immediately and being supported to continue breastfeeding as long as you wish
- Being provided with information about and support in caring for your child in the first months and years of life
- Receiving information about family planning so you can efficiently space your next pregnancy
- Being supported by the midwifery team to access child and family health services and vaccination programmes at the appropriate time

**WHAT MAKES THIS POSSIBLE?**

1. All women of reproductive age, including adolescents, have universal access to midwifery care when needed.
2. Governments provide and are held accountable for a supportive policy environment.
3. Governments and health systems provide and are held accountable for a fully enabled environment.
4. Data collection and analysis are fully embedded in service delivery and development.
5. Midwifery care is prioritized in national health budgets; all women are given universal financial protection.
6. Midwifery care is delivered in collaborative practice with health-care professionals, associates and by health workers.
7. First-level midwifery care is close to the woman and her family with seamless transfer to next-level care.
8. The midwifery workforce is supported through quality education, regulation and effective human and other resource management.
9. All health-care professionals provide and are enabled for delivering respectful quality care.
10. Professional associations provide leadership to their members to facilitate quality care provision.
Midwifery in (social) enterprise

**Jacaranda Health**

- social venture combining business and clinical innovations
- women living in Nairobi’s peri-urban areas
- high-quality, friendly and affordable maternal care through a network of self-sustaining and scalable clinics

“a global innovation laboratory, adapting and integrating the best clinical protocols, technologies, health information systems, and business approaches”.

Patient-centred, data-driven, task-shifting, word-of-mouth marketed, behaviour-changing (especially men).
Manoshi

Bringing MNH services to the slums of Bangladesh
- Clean birthing centres
- Services close to the community + outreach
- Facilitated transportation and access to referral level care
- Full continuum of care, including post-natal and early years of life
- Free of charge in the slums with financial support for referral level services if needed
- Using ‘local’ staff
The impact of being a midwife

**Afghanistan community midwife programme**

- Education programme started in the early noughties to help fight the extreme maternal mortality ratio of 1,800/100,000 live births
- 30 midwifery schools, in 25 of the 34 provinces, >3000 educated
- Midwives association established in 2006
- Primary contributors to the >50% reduction in maternal mortality
- Women became more visible, generated ‘standing’ in their communities, invited to meet with the elders, consulted on ‘all and sundry’ regarding women’s health and other issues in their communities.
Community Based Midwifery Diploma Program, BRAC University

- Hub and spoke model for curriculum development, faculty development, training site development and student selection
- Locally recruited students at the ‘spoke’ schools, following ‘hub’ curriculum. Remain in their regions when they graduate*.
- Comparing the cost of this education programme (£10,000/midwife) and based on an assumption of 30-years of active practice, the 500 midwives developed through this programme, could save/prevent:
  - 34,178 infant lives and 2001 maternal lives. Total of 2,635,164 life years at the cost of £138 per life saved, or £1.90 per life year saved.
  - 3,391 C-sections per year (101.719 total)(25% reduction), avoiding £80,982,655 in cost and generating a 16-fold return on investment for their education
  - Morbidities including anaemia, fistula, uterine rupture, prolaps, maternal mental health etc

*VFM analysis, Tim Evans, April 9th 2013
Midwifery-led Units

- Cochrane review Sandall, 2013, midwifery-led units vs other models of care for childbearing women and their infants.
  - Less regional analgesia, intrapartum analgesia/anaesthesia, episiotomy and instrumental birth
  - More spontaneous birth, attendance by a known midwife
  - Longer mean length of labour, no difference in c-sections
  - Less pre-term birth, foetal loss before 24 weeks (no difference >24 weeks) and less overall foetal/neonatal loss
  - Higher rate of maternal satisfaction
  - Lower cost (confirmed by the M@NGO trial, Tracy et al, 2013)
Conclusion

Hub-and-spoke model of midwife-led units close to referral facilities with outreach to communities and inclusion of CHWs under supervision of the midwife, using modern technology.

Idea by Emily Friedberg, March 2011, on OpenIdeo
Grow incrementally

- GHWA session on the cost-effectiveness of CHWs, May 2014
- Obstetric transition*
  - Stage I, MMR>1000, high fertility, direct causes, high communicable diseases
  - Stage II, MMR 999-300, same as Stage I, but with more women seeking care in facilities, low education, few health care providers, poor QoC
  - Stage III, MMR 299-50, variable fertility, restricted access to facilities, increased 2nd & 3rd levels of care, more providers available, intra-hospital QoC an issue,
  - Stage IV, MMR<50, low fertility, low direct causes, more indirect causes (NCDs), health system delays still high, overmedicalisation
  - Stage V, low MMR, all avoidable death avoided, low fertility, NCDs and other indirect causes are the main causes of death, main issues are gender inequality and vulnerable population
- HRH transition needs to be in sync with these kinds of transitions

*JP. Souza et al, Obstetric transition: the pathway to ending preventable maternal deaths, BJOG 2014